



## **DEPARTMENT OF HEALTH AND HUMAN SERVICES**

### **Centers for Medicare & Medicaid Services**

**[CMS-3404-FN]**

### **Medicare and Medicaid Programs; Application from the Joint Commission for Continued Approval of its Hospice Accreditation Program**

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), Health and Human Services (HHS).

**ACTION:** Final notice.

**SUMMARY:** This final notice announces our decision to approve The Joint Commission for continued recognition as a national accrediting organization for hospices that wish to participate in the Medicare or Medicaid programs.

**DATES:** The decision announced in this notice is effective on June 18, 2021 through June 18, 2025.

**FOR FURTHER INFORMATION CONTACT:** Caecilia Blondiaux, (410) 786-2190.

### **SUPPLEMENTARY INFORMATION:**

#### **I. Background**

Under the Medicare program, eligible beneficiaries may receive covered services from a hospice provided certain requirements are met. Section 1861(dd) of the Social Security Act (the Act) establish distinct criteria for facilities seeking designation as a hospice. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities are at 42 CFR part 488. The regulations at 42 CFR part 418 specify the minimum conditions that a hospice must meet to participate in the Medicare program.

Generally, to enter into an agreement, a hospice must first be certified by a state survey agency (SA) as complying with the conditions or requirements set forth in part 418 of our

regulations. Thereafter, the hospice is subject to regular surveys by a SA to determine whether it continues to meet these requirements. There is an alternative; however, to surveys by SAs.

Section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation by Centers for Medicare & Medicaid Services (CMS)-approved national accrediting organization (AO) that all applicable Medicare requirements are met or exceeded, we will deem those provider entities as having met such requirements. Accreditation by an AO is voluntary and is not required for Medicare participation.

If an AO is recognized by the Secretary of the Department of Health and Human Services as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program would be deemed to meet the Medicare conditions. A national AO applying for approval of its accreditation program under part 488, must provide CMS with reasonable assurance that the AO requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the approval of AOs are set forth at §§ 488.4 and 488.5. The regulations at § 488.5(e)(2)(i) require AOs to reapply for continued approval of its accreditation program every 6 years or sooner, as determined by CMS.

The Joint Commission's (TJC's) current term of approval for their hospice accreditation program expires June 18, 2021.

## **II. Application Approval Process**

Section 1865(a)(3)(A) of the Act provides a statutory timetable to ensure that our review of applications for CMS-approval of an accreditation program is conducted in a timely manner. The Act provides us 210 days after the date of receipt of a complete application, along with any documentation necessary to make our determination, to complete our survey and review activities. Within 60 days after receiving a complete application, we must publish a notice in the **Federal Register** that identifies the national accrediting body making the request, describes the request, and provides no less than a 30-day public comment period. At the end of the 210-day

period, we must publish notice in the **Federal Register** of our decision to approve or deny the application.

### **III. Provisions of the Proposed Notice**

On November 9, 2020, we published a proposed notice in the **Federal Register** (85 FR 71343), announcing TJC's request for continued approval of its Medicare hospice accreditation program. In the November 9, 2020 proposed notice, we detailed our evaluation criteria. Under section 1865(a)(2) of the Act and in our regulations at § 488.5, we conducted a review of TJC's Medicare hospice accreditation application in accordance with the criteria specified by our regulations, which include, but are not limited to the following:

- An onsite administrative review of TJC's: (1) corporate policies; (2) financial and human resources available to accomplish the proposed surveys; (3) procedures for training, monitoring, and evaluation of its hospice surveyors; (4) ability to investigate and respond appropriately to complaints against accredited hospices; and (5) survey review and decision-making process for accreditation.

- The comparison of TJC's Medicare hospice accreditation program standards to our current Medicare hospice conditions of participation (CoPs).

- A documentation review of TJC's survey process to do the following:

- ++ Determine the composition of the survey team, surveyor qualifications, and TJC's ability to provide continuing surveyor training.

- ++ Compare TJC's processes to those we require of SAs, including periodic resurvey and the ability to investigate and respond appropriately to complaints against TJC-accredited hospices.

- ++ Evaluate TJC's procedures for monitoring and follow up with its accredited hospices, which it has found to have deficiencies and are out of compliance with TJC's program requirements. (This pertains only to monitoring procedures when TJC identifies non-compliance. If noncompliance is identified by a SA through a validation survey, the SA

monitors corrections as specified at § 488.9(c)).

++ Assess TJC's ability to report deficiencies to the surveyed hospice and respond to the hospice's plan of correction in a timely manner.

++ Establish TJC's ability to provide CMS with electronic data and reports necessary for effective validation and assessment of the organization's survey process.

++ Determine the adequacy of TJC's staff and other resources.

++ Confirm TJC's ability to provide adequate funding for performing required surveys.

++ Confirm TJC's policies with respect to surveys being unannounced.

++ Confirm TJC's policies and procedures to avoid conflicts of interest, including the appearance of conflicts of interest, involving individuals who conduct surveys or participate in accreditation decisions.

++ Obtain TJC's agreement to provide CMS with a copy of the most current accreditation survey together with any other information related to the survey as we may require, including corrective action plans.

#### **IV. Analysis of and Responses to Public Comments on the Proposed Notice**

In accordance with section 1865(a)(3)(A) of the Act, the November 9, 2020 proposed notice also solicited public comments regarding whether TJC's requirements met or exceeded the Medicare CoPs for hospices. No comments were received in response to our proposed notice.

#### **V. Provisions of the Final Notice**

##### **A. Differences Between TJC's Standards and Requirements for Accreditation and Medicare Conditions and Survey Requirements**

We compared TJC's hospice accreditation requirements and survey process with the Medicare CoPs in part 418, and the survey and certification process requirements in parts 488 and 489. Our review and evaluation of TJC's hospice application, which were conducted as described in section III of this final notice, yielded the following areas where, as of the date of

this notice, TJC has completed revising its standards and certification processes in order to--

- Meet the standard requirements in all the following regulations:

++ Section 418.52(b)(2), to include language in TJC's comparable standard to specify that if a patient has been adjudged incompetent under state law by a court of proper jurisdiction, as part of the conditions of participation (CoP) relating to patient's rights, the rights of the patient are exercised by the person appointed to act on their behalf.

++ Section 418.52(b)(3), to revise existing language related to the patient's rights CoP; TJC's documentation also refers to a surrogate-decision maker, which may have different implications than the term "legal representative" used in regulations.

++ Section 418.52(b)(4)(i) and (ii), to require that the hospice must immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice, and to include language related to mistreatment (verbal or mental) and misappropriation of patient property and the need to immediately take action to prevent further potential violations while the alleged violation is being verified.

++ Section 418.54, to include language related to all aspects of the required patient-specific comprehensive assessment, including emotional/psychosocial assessment in addition to the pain/symptom assessment; functional status; and general physical assessment, to be included in writing in the initial and comprehensive assessment, to more closely align with the regulatory language.

++ Section 418.56(e), to incorporate language requiring that hospices must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures that reflects its responsibility to direct and coordinate care.

++ Section 418.58(d), to include that hospices must have developed, implemented, and evaluate performance improvement projects.

++ Section 418.60, to include language requiring the hospice to maintain and document an effective infection control program that protects patients, families, visitors, and

hospice personnel by preventing and controlling infections and communicable diseases.

++ Section 418.62(c), to add participation in hospice sponsored in-service training under the requirement applicable to licensed professionals.

++ Section 418.64(b)(1), to include comparable language that nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments.

++ Sections 418.66(a) and 418.74, to clarify its discussion of the applicable requirements by including specific language related to hospices operating in non-urbanized areas, specifically in regard to physical therapy, occupational therapy, speech-language pathology, and dietary counseling waivers, and the process of submission of such waivers for CMS approval.

++ Section 418.76(c)(5), to include that hospices must maintain documentation demonstrating that hospice aide services are provided by competent individuals.

++ Section 418.76(h)(1), to remove language suggesting that “If nursing services are not provided, a physical or occupational therapist or speech-language pathologist can supervise the hospice aide” and to reflect the fact that “the supervising individual” must be a Registered Nurse, and is required to make an onsite visit to hospice patients.

++ Sections 418.78(b) and (e) and 418.100(b), to specify the requirements related to daily activities of volunteers.

++ Section 418.100(e) and (g)(3), to specify relevant requirements relating to professional management and training, including adding key terminology relating to financial management and qualified personnel to align with the requirements for organization and administration of services.

++ Section 418.106(d)(1), to include reference to the interdisciplinary group.

++ Section 418.110(f) and (g)(1), to include the term dignity as it relates to the atmosphere set in patient care areas.

++ Section 418.110(m)(1), to appropriately reference the plan of care within TJC's comparable standard.

In addition to the standards review, CMS also reviewed TJC's comparable survey processes, which were conducted as described in section III of this final notice, and yielded the following areas where, as of the date of this notice, TJC has completed revising its survey processes in order to demonstrate that it uses survey processes comparable to SA processes by taking the following steps:

++ Removing language in award letters or communications with TJC's accredited hospices, which referenced "lengthen the duration of the cycle" beyond the allowable 36-month period, which is inconsistent with the regulatory requirements at § 488.5(a)(4)(i).

++ Providing additional training to surveyors on citing the appropriate levels of noncompliance, as it relates to the scope, manner and degree of deficiencies (condition level versus standard level deficiencies), in the initial comprehensive assessment.

++ Providing additional surveyor training and tools under TJC's Surveyor Technology to ensure surveyors properly document reviews of personnel files and credentialing as part of the survey process.

#### B. Term of Approval

Based on our review and observations described in sections III and V of this final notice, we approve TJC as a national accreditation organization for hospices that request participation in the Medicare program. The decision announced in this final notice is effective June 18, 2021 through June 18, 2025 (4 years). Due to travel restrictions and the reprioritization of survey activities brought on by the 2019 Novel Coronavirus Disease (COVID-19) Public Health Emergency (PHE), CMS was unable to observe a hospice survey completed by TJC surveyors as part of the application review process, which is one component of the comparability evaluation. Therefore, we are providing TJC with a shorter period of approval. Based on our discussions with TJC and the information provided in its application, we are confident that TJC

will continue to ensure that its accredited hospices will continue to meet or exceed Medicare standards. While TJC has taken actions based on the findings annotated in section V.A. of this final notice, (Differences Between TJC’s Standards and Requirements for Accreditation and Medicare Conditions and Survey Requirements) as authorized under § 488.8, we will continue ongoing review of TJC’s hospice survey processes and will conduct a survey observation once the COVID–19 PHE has expired.

## VI. Collection of Information

This document does not impose information collection requirements, that is, reporting recordkeeping or third party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

The Acting Administrator of the Centers for Medicare & Medicaid Services (CMS), Elizabeth Richter, having reviewed and approved this document, authorizes Lynette Wilson, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Dated: March 24, 2021.

**Lynette Wilson,**

Federal Register Liaison,

Centers for Medicare &amp; Medicaid Services.